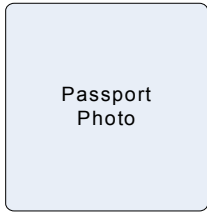


**THE ALLIED HEALTH PROFESSIONALS COUNCIL
MINISTRY OF HEALTH**



OFFICIAL USE

Status:
Amount:
Signature:

APPLICATION FORM FOR REGISTRATION-AHPC-form 1

1. i) INDIVIDUAL INFORMATION (BLOCK LETTERS)

Surname:First Name:
Other names:
Gender (tick): Male Female Date of Birth:
Nationality:Country:
District:Sub county:
Marital Status:Tribe:

ii) CONTACT ADDRESS

i) Personal

Address: Residence:
Telephone No:Alternate Telephone No:.....
Email address:

ii) Work Place

Place of work:.....
Address:Telephone No:.....
Locality:.....District:.....

2. EDUCATION INFORMATION

Secondary School attended :(Please attach copies)

O' Level: Index Number.....
A' level:Index Number:.....

4. TRAINING INFORMATION

Training Institution:

.....
.....

Country of Training:

Contact address of Institution:

Tel number..... E-mail

Intake date:Date of Completion:

Reg No Hospital of training:

Masters Degree Diploma Certificate

Qualification type:

Qualification:

Cadre:

Have you ever registered before? (If yes, attach details)

Date of registration: Signature.....

FOR OFFICIAL USE ONLY

Registration no: Date of verification:

Comments:.....

.....
.....

Name.....Title:.....signature.....